No. 89-1048

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

FMC CORPORATION,
Petitioner,
v.
CYNTHIA ANN HOLLIDAY,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA, AS AMICUS CURIAE, IN SUPPORT OF THE PETITIONER

Of Counsel:
STEPHEN A. BOKAT
MONA C. ZEIBERG
CHAMBER OF COMMERCE
OF THE UNITED STATES
OF AMERICA
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

MORGAN, LEWIS & BOCKIUS
1800 M Street, N.W.
Washington, D.C. 20036
(202) 467-7000

HARRY A. RISSETTO *
E. CARL UEHLEIN, JR.
MARGERY SINDER FRIEDMAN
LARISSA OMELCHENKO TARAN
1800 M Street, N.W.
Washington, D.C. 20036
(202) 467-7130

* Counsel of Record

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

TABLE OF AUTHORITIES—Continued

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INTEREST OF AMICUS CURIAE

With the written consent of the parties,[1] the Chamber of Commerce of the United States ("Chamber") submits this brief as amicus curiae in support of the Petitioner. The Chamber is the nation's largest federation of business, trade and professional organizations in the United States. It represents the interests of over 180,000 corporations, partnerships and proprietorships, as well as several thousand state and local chambers of commerce and trade associations. An important function of the Chamber is to represent the interests of its member employers in important labor relations matters before this

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[1] Pursuant to Supreme Court Rule 37.2, the consent letters have been filed with the Clerk of this Court.

Court, the lower courts, the United States Congress, the Executive Branch and independent regulatory agencies of the federal government. This representation constitutes a significant aspect of the Chamber's activities. Accordingly, the Chamber has sought to advance those interests by filing briefs in a wide spectrum of labor relations litigation,[2] including this case, in which the Chamber urged the Court to grant certiorari.

In the decision below, the Third Circuit Court of Appeals rejected this Court's bright-line preemption test under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, which established that state regulation of uninsured employee benefit plans is preempted by ERISA, even where the state acts through its insurance laws which are generally "saved" from preemption. Instead, the Court of Appeals crafted its own test, permitting a Pennsylvania antisubrogation law to apply to uninsured plans, because the law purportedly did not address "core ERISA concerns."

The Third Circuit decision threatens to disrupt the ability of many Chamber members to continue to maintain and operate their self-insured employee benefit plans. It also jeopardizes the financial stability of uninsured, collectively bargained multiemployer plans, to which many Chamber members contribute. By prohibiting uninsured plans from using subrogation rules as a cost containment mechanism, the Third Circuit decision will inevitably result in substantial increases in the benefit costs of these plans. Further, the decision will encourage other states to delve into employee benefit plan regulation, which will increase administrative costs and expose uninsured plans to the threat of conflicting re-

[2] *E.g., Trans World Airlines, Inc. v. Independent Federation of Flight Attendants*, 109 S.Ct. 1225 (1989); *Laborers Health and Welfare Trust Fund v. Advanced Lightweight Concrete Co., Inc.*, 484 U.S. 539 (1988); *Pattern Makers League v. NLRB*, 473 U.S. 95 (1985).

quirements. Chamber members thus have a compelling interest in seeking to prevent any erosion in this Court's commitment to comprehensive federal preemption. This interest puts the Chamber in a position to provide the Court with a more complete understanding of the potential impact of the Third Circuit decision, and of the necessity for this Court to act to preserve both the viability of uninsured benefit plans and their exclusively federal scheme of regulation.

SUMMARY OF ARGUMENT

In attempting to "make sense" of ERISA's interlocking preemption provisions, the United States Court of Appeals for the Third Circuit has adopted an unprecedented approach which purports to permit a "rational system" of state and federal law to apply uniformly to insured and uninsured employee benefit plans. Rejecting the unanimous view of eight Justices of this Court, who held that ERISA preempts the application of state insurance laws to uninsured plans, the Third Circuit concluded that state laws purporting to regulate "insurance" may apply to uninsured employee benefit plans as long as they do not address "core ERISA concerns." In adopting this approach, however, the Court of Appeals ignored fundamental, historical distinctions between the business of insurance and employee benefit plans, and overlooked critical differences between insured and uninsured plans—differences which render uninsured plans acutely vulnerable to the threat of dual state and federal regulation.

Several factors support the application of different rules under ERISA for insured and uninsured plans. First, Congress' decision to save state insurance laws from ERISA preemption was consistent with its deferral to state regulation in the McCarran-Ferguson Act of 1945, Ch. 20, 59 Stat. 33 (1945), and its decision at that time that continued state regulation of the business

of insurance was in the public interest. By contrast, when Congress enacted ERISA in 1974, it determined that adequate safeguards concerning the operation of employee benefit plans were lacking, thus making federal regulation of those plans desirable.

Second, the nature and operation of employee benefit plans make it inappropriate for them to be subject to state insurance laws designed to regulate commercial businesses and to protect consumers. While insurance companies are businesses, selling consumer products to the public, welfare benefit plans are non-profit entities which exist to provide benefits only to sponsoring employers' employees. They do not market their products to outside groups or to the public at large.

Third, Congress could not have accomplished its goal of eliminating the threat of conflicting and inconsistent employee benefit plan regulation without exempting uninsured plans from state regulation. Although a plan which purchases an insurance policy may rely on the insurance company to comply with any state laws affecting the company, an uninsured plan subject to state insurance laws would itself become responsible for sorting through various and conflicting state requirements. By failing to recognize the adverse impact that its decision would have on uninsured plans, and by ignoring the intent of Congress to eliminate a "patchwork scheme of regulation," the Third Circuit reached a conclusion which can never make sense under the ERISA regulatory scheme.

If, as a result of the decision below, uninsured plans are now forced to comply with various state insurance laws, their administrative costs will undoubtedly increase. More significantly, the Third Circuit analysis will drive up the benefit costs of uninsured plans. Subrogation rules are included in many plans' cost containment efforts, and are designed to maximize the protection available to all plan participants by providing benefits only to those individuals who have no other avenues of recovery. If employers and plan administrators are prevented from using these cost containment features, benefit costs will increase.

In order to respond to the pressures created by state-mandated benefit increases, employers may conclude that they have to reduce plan benefits. One alternative, already embraced by some plans, would be to eliminate coverage entirely for medical costs arising out of automobile accidents. If injuries and illnesses arising out of automobile accidents are not covered at all by a plan, the subrogation issue would not arise. A change in coverage of this magnitude, however, could have disastrous consequences for the participants of uninsured plans. In some cases, participants may have no coverage at all for their medical claims. Thus, instead of permitting double recoveries, as the Pennsylvania statute was designed to do, state anti-subrogation laws may result in no available recovery for individuals otherwise covered by employee benefit plans.

Finally, the vagueness of the "core ERISA concerns" test virtually guarantees a long period of uncertainty during which the states will test the outer limits of their newly-found authority to regulate plans. Plans and employers, on the other hand, will be fighting to preserve some semblance of ERISA's originally intended preemption, while at the same time struggling to comply with conflicting laws. When these conflicting interests are brought before the federal courts, judges will be forced to sort through an endless series of disputes over the meaning and scope of the Third Circuit test. Accordingly, this Court should reverse the decision below and restore order to the regulation of employee welfare benefit plans.

ARGUMENT

I. THE THIRD CIRCUIT'S ATTEMPT TO "MAKE SENSE" OUT OF ERISA'S PREEMPTION PROVISIONS FAILS BECAUSE IT IGNORES FUNDAMENTAL DISTINCTIONS BETWEEN THE BUSINESS OF INSURANCE AND EMPLOYEE BENEFIT PLANS, AND BETWEEN INSURED AND UNINSURED PLANS

The Third Circuit's unprecedented preemption analysis is rooted in its desire to "make sense" of ERISA's interlocking preemption provisions.[3] *FMC Corp. v. Holliday*, 885 F.2d 79, 88 (3d Cir. 1989) ("FMC"). However, in its attempt to create a "rational system" of state and federal law which would apply uniformly to insured and uninsured employee benefit plans,[4] the Third Circuit

[3] Section 514(a) of ERISA generally provides that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." Section 514(b)(2)(A), often referred to as the "savings" clause, states that except as provided in subparagraph (B), nothing in Title I of ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(a), (b)(2)(A). Section 514(b)(2)(B) of ERISA, known as the "deemer" clause, provides that "[n]either an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer . . . or be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts. . . ." 29 U.S.C. § 1144(b)(2)(B).

[4] The Third Circuit relied heavily in its decision on the analysis of the Sixth Circuit Court of Appeals in *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 108 S.Ct. 1754 (1988) ("*Northern Group Services*"), which held that ERISA does not preempt the application of state-mandated coordination of benefits rules under a Michigan no-fault automobile insurance law to uninsured plans. Both of these Circuit Courts strained to reach a result preserving a uniform application of state laws to all employee benefit plans, "so that benefit obligations are governed by a rational system of state law and federal

ignored fundamental, historical distinctions between the business of insurance—which may be regulated by the states—and employee benefit plans, which may not. The Third Circuit approach also ignored critical differences between insured and uninsured plans—differences which render uninsured plans acutely vulnerable to the threat of dual state and federal regulation.

In reaching its desired result, the Third Circuit ignored this Court's carefully reasoned ERISA preemption analysis in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985) ("*Metropolitan Life*"). In *Metropolitan Life*, the Court held that where an employee benefit plan purchases an insurance contract from an insurance carrier subject to state regulation, the plan may be subject to indirect state regulation because ERISA expressly excludes from its broad preemption provision state laws regulating insurance. 471 U.S. at 747; Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A). Where an employee benefit plan is uninsured, however, it may not be subject to state insurance laws, because ERISA expressly prohibits the states from deeming an employee benefit plan to be an insurance company or in the business of insurance for purposes of a state law regulating insurance. *Metropolitan Life*, 471 U.S. at 747; Section 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B).

A. Historical And Functional Differences Between The Business Of Insurance And Employee Benefit Plans Justify Different Rules Under ERISA

Significant distinctions between the business of insurance and the operations of employee benefit plans support the Congressionally-designed regulatory scheme prohibiting the application of state laws where true insurance is not involved. When Congress chose to "save"

common law." *FMC*, 885 F.2d at 84, *quoting Northern Group Services*, 833 F.2d at 89.

from preemption state laws regulating insurance, it was doing no more than continuing its historical deferral to state regulation in this area. The insurance industry has traditionally been subject to extensive state regulation—indeed, Pennsylvania insurance legislation dates back to at least 1810. Pa. Stat. Ann. tit. 40 §§ 1 to 720, Introduction p. XXI (Purdon 1971).

Congress' decision to save state insurance laws from ERISA preemption was consistent with its declaration in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.* (1976 & Supp. V 1982), "that the continued regulation and taxation by the several states of the business of insurance is in the public interest." By contrast, Congress determined when it enacted ERISA that despite the recent growth in size, scope, and numbers of employee benefit plans, adequate safeguards concerning their operation were lacking, thus making federal regulation desirable. *See* Findings and Declaration of Policy, Section 2(a) of ERISA, 29 U.S.C. § 1001(a).

Allowing the states to continue to regulate insurance companies, while preventing them from regulating em-employee benefit plans, had a logical as well as historical basis. Insurance companies (which generally operate on a for-profit basis) are businesses, selling traditionally-regulated consumer products to unrelated customers. Insurance companies compete with each other for business, and advertise and market their products within the business community and to the public at large.

By contrast, uninsured employee welfare benefit plans are not in the business of selling consumer insurance products. They are non-profit entities that exist to provide benefits only to sponsoring employers' employees. They do not market their wares to outside groups or to the public, and they do not attempt to broaden their base by selling coverage to unrelated beneficiaries. These distinctions more than justify Congress' refusal to permit the states to extend application of their traditional,

consumer-protection insurance statutes directly to employee benefit plans.[5]

B. Uninsured Plans Have A Particular Need For Complete Protection From State Insurance Laws

Even more importantly, however, critical distinctions between the operations of insured and uninsured plans meant that the Congressional goal of "eliminating the threat of conflicting and inconsistent State and local regulation"[6] of employee benefit plans could not have been accomplished without a comprehensive clause protecting uninsured plans from state regulation. State regulation of the business of insurance and of insurance companies did not threaten the viability of employee benefit plans, even where those plans purchased insurance policies. In contrast, Congress had to exempt uninsured plans from state regulation in order to ensure that those plans would not be overwhelmed by conflicting requirements.

When an employer or employee benefit plan purchases insurance from an insurance company, the plan does not itself become subject to state laws or responsible for determining the insurance company's compliance in various states. It is the insurance company's obligation to monitor the state laws that are applicable to it, and to make certain that the insurance contracts it sells are in compliance with those laws. Assumption of the ad-

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[5] State insurance laws are commonly understood to be consumer protection statutes, regulating the sale of consumer products. *See* Collins, *Regulation Best on State Level: Washburn*, Bus. Ins., May 2, 1988, at 69; Howard, *States to Keep Ins. Regulation*, Nat'l Underwriter, June 26, 1989, at 3; Fisher, *Agents, Consumer Groups Seek Regulatory Standards*, Nat'l Underwriter, June 12, 1989, at 1; Jones, *The Industry Doesn't Need a Federal 'Czar,'* Nat'l Underwriter, November 7, 1988, at 19.

[6] 120 Cong. Rec. 29197 (1974) (statement of Rep. John Dent), *quoted in Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 (1983).

ministrative burden associated with different state insurance laws is an essential component of the insurance product purchased by an employee benefit plan.

Thus, the states do not in fact regulate the employee benefit plans that purchase insurance policies. Rather, the insurance companies are regulated, and plans simply choose among the types of policies that the various states permit to be marketed.

By contrast, if the decision below is not overturned, and if state insurance laws are applied to uninsured employee benefit plans, the plans themselves will be required to monitor and comply with extensive state regulation. This Court has already found that Congress intended ERISA's preemption provision to eliminate "[a] patchwork scheme of regulation," because the inefficiencies introduced thereby "might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 11 (1987). As the Court recognized, "[p]reemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations." *Id.*

By ignoring critical distinctions between insured and uninsured plans, the Third Circuit failed to recognize that it could never make sense under the ERISA scheme of regulation to permit states to apply their insurance laws directly to employee benefit plans. If the Third Circuit decision is not reversed, those plans and their sponsoring employers will be forced to shoulder the burden of dual and conflicting regulation. Thus, despite the Third Circuit's rejection of the logic behind this Court's decision in *Metropolitan Life*, the preemption analysis so clearly articulated in that case must remain intact.

II. IF THE THIRD CIRCUIT DECISION IS NOT REVERSED, UNINSURED PLANS WILL BE FORCED TO RESPOND TO UNWARRANTED INCREASED ADMINISTRATIVE AND BENEFIT COSTS, WHICH MAY JEOPARDIZE THE CONTINUED DELIVERY OF COMPREHENSIVE MEDICAL BENEFITS TO PLAN PARTICIPANTS

An employer's choice to self-insure its employee health plan is most often an economic decision—administrative costs for uninsured plans are generally lower than for insured plans.[7] In addition, employers insuring their own plans can achieve savings by holding onto cash until claims are paid, instead of paying premiums in advance to an insurer.[8] These cost-saving devices are extremely important to health plans, because employers are limited in the amounts they can make available to finance plan benefits. Where plans are funded, such as in the case of collectively-bargained, jointly administered plans, the trusts derive their assets solely from limited negotiated contributions and the interest generated by any reserves held. In addition, contribution levels are often fixed for the terms of the underlying collective bargaining agreements and may lag behind ever-rising medical plan costs.

Despite the administrative cost savings that are generally available to uninsured plans, there has been a

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[7] Burcke, *Administrative Costs Lower Among Self Insurers: Study*, Bus. Ins., February 13, 1989 at 28, *citing* Foster Higgins, *Health Care Benefits Survey—1988*, at 24 (health care administrative expenses for self-insured employers total 5.2% of claims, while insured employers' administrative expenses total 6.6% of paid claims). One author attributes recent growth in self-insurance to ever-increasing health premium costs. *See* Donahue, *53% of Group Health Plans Are Now Self-Insured: HIAA*, Nat'l Underwriter, June 13, 1988, at 13 (based on a 1987 survey of 771 employers by the Health Insurance Association of America).

[8] Foster Higgins, *supra* note 7, at 23.

dramatic upturn in medical plan costs in recent years.[9] Although this increase has affected both insured plans and uninsured plans, uninsured plans experienced its impact sooner.[10] If, as a result of the Third Circuit decision, uninsured plans are now forced to comply with various state insurance laws, their administrative costs will undoubtedly increase.

Even more significant, however, is that the Third Circuit analysis will drive up the benefit costs of uninsured plans. As a result of increased medical costs, plan administrators and plan boards of trustees have been forced to rely on aggressive cost containment measures. Subrogation rules and plan-created coordination of benefits provisions, like those struck down by the Third Circuit in the decision below and by the Sixth Circuit in *Northern Group Services*, 833 F.2d 85, are designed to maximize the protection available to all participants by denying coverage or limiting benefits in many cases where individuals have other avenues of recovery.[11] If

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[9] Shalowitz, *Self-Insurance—Self-Funding Benefits at Peak of Popularity?*, Bus. Ins., January 30, 1989, at 3.

[10] Foster Higgins, *supra* note 7, at 22. The Foster Higgins Survey made the following comment with respect to 1988 cost increases:

> The severity of this year's increase took many by surprise—including, it seems, the insurance industry. Employers with insured programs experienced an average increase of only 13.7 percent in 1988. Self-funded plans, on the other hand, averaged a 24.8 percent increase in the same period. Clearly, the projected trend for 1988, as reflected in the rate of increase for insured plans, was far exceeded by the actual experience during the period, as demonstrated by the experience of the self-funded employers. It is likely that those fully insured or experience-rated plans will find their 1989 premiums reflecting the deficit caused by the understated 1988 trend.

Id. at 12.

[11] The savings derived from rules of this type can be substantial:

> Savings arising from enforcement of Coordination of Benefits (COB) provisions averaged 5.1 percent of total plan payments in 1988, ranging from an average of 4.9 percent among employers using commercial carriers to an average of 5.8 percent among self-administered employers.

Foster Higgins, *id.* at 27.

employers and plan administrators are now to be prevented from using these cost containment features of plan design, benefit costs will increase.

In order to respond to the pressures created by state-mandated benefit increases, employers may conclude that they have to reduce plan benefits. Employers could choose to reduce benefits across-the-board, or to address the benefit increases caused by state anti-subrogation laws more directly. One alternative for plans subject to the statute addressed in *FMC* would be to eliminate coverage entirely for medical costs arising out of automobile accidents. If injuries and illnesses arising out of automobile accidents are not covered at all by the plan, the subrogation issue would not arise. *Cf. Liberty Mutual Insurance Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989) (coordination of benefits rules of Michigan no-fault insurance laws preempted where health plan excluded coverage for automobile accidents).

As demonstrated by the *Liberty Mutual* decision, plans have already begun to embrace this alternative as a means of avoiding the benefit increases that would result from the Third and Sixth Circuit decisions. A change in coverage of this magnitude, however, could have disastrous consequences for the participants of uninsured plans. In some cases, participants may have no coverage at all for their medical claims.[12] Thus, instead

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[12] For example, in the instant case, Respondent Holliday was limited in her recovery from the alleged tortfeasor in her automobile accident case to approximately $50,000, despite the fact that her medical bills have thus far exceeded twice that amount. An uninsured motorist or pedestrian who finds himself at fault in an automobile accident might have no avenue of recovery if coverage is denied under his employee benefit plan.

of permitting double recoveries, as the Pennsylvania statute was designed to do, state anti-subrogation laws may result in no available recovery for individuals otherwise covered by employee benefit plans.

Moreover, many employers and plans have routinely covered the medical benefit costs of employees in situations where plan coverage was in question, as a convenience to these employees. In cases where an employee's recovery from another entity is uncertain or likely to be delayed for some period of time, as in Respondent Holliday's case, a plan's early provision of benefits performs a genuine service. Subrogation rules have served to protect the employers and plans from ultimately being responsible for benefits that were not intended to be covered. If statutes such as Pennsylvania's anti-subrogation law are held to survive ERISA preemption, this early and necessary protection for employees injured in automobile accidents may be eliminated. These victims could then be subjected to serious delays in securing reimbursement for medical costs. Further, any open question as to an individual's eventual recovery of medical costs could affect his ability to receive the medical care of his choice.

III. IF LEFT UNDISTURBED, THE THIRD CIRCUIT DECISION WILL PROVOKE UNCERTAINTY AND FOSTER UNNECESSARY LITIGATION AS THE FEDERAL COURTS STRUGGLE TO APPLY AN INHERENTLY CONFUSING AND UNWORKABLE PREEMPTION TEST

The vagueness of the "core ERISA concerns" test—under which state laws purporting to regulate "insurance" may be applied to uninsured employee benefit plans as long as they address areas other than reporting, disclosure and nonforfeitability of benefits [13]—virtually

[13] Although the opinion is far from clear, the Third Circuit's discussion of the legislative history of ERISA's preemption provision suggests that the area of fiduciary responsibility would also be a "core ERISA concern." *See FMC*, 885 F.2d at 87-88. In addition, the Third Circuit's designation of nonforfeitability as a "core ERISA concern" suggests that other subject areas covered by ERISA might also be considered "core" matters, even though they (like nonforfeitability) are not applicable to welfare plans. *See* Section 201(1) of ERISA, 29 U.S.C. § 1051(1) (excluding employee welfare benefit plans from ERISA's nonforfeitability rules).

guarantees a long period of uncertainty during which the states will test the outer limits of their newly-found authority to regulate plans. Plans and employers, on the other hand, will be fighting to preserve some semblance of ERISA's originally intended preemption, while at the same time struggling to comply with conflicting laws.

Any state that accepts the Third Circuit's open invitation to regulate employee welfare plans can be expected to attempt to apply the same extensive requirements that are prevalent in state insurance regulation to employee benefit plans. Although it would be impossible to predict just how far the states will be willing to go in this area, one can assume that various (and conflicting) anti-subrogation rules and coordination of benefits laws will be imposed, along with rules relating to benefits processing and the timeliness of payment of claims.[14] The states may even attempt to impose minimum asset (actuarial reserve) requirements and other traditional "insurance" obligations on uninsured plans.[15] The possibilities are endless, and all are contrary to this Court's preemption analysis and the Congressional intent underlying ERISA.

[14] *See, e.g.*, Ill. Ann. Stats., Chap. 73, §§ 964, 969 (Smith-Hurd 1988); Ohio Rev. Code Ann. § 3901.38 (Anderson 1989); Tenn. Code Ann. § 68-11-219 (1988). These rules would directly conflict with ERISA's claims procedure requirements, *see* 29 C.F.R. § 2560.503-1 (1989), but could, nonetheless, be found not to address reporting, disclosure and nonforfeitability.

[15] *See, e.g.*, Pa. Stat. Ann. tit. 40, § 93 (Purdon 1971). Actuarial reserve requirements are nothing more than minimum funding requirements, which ERISA limits to pension plans. *See* Section 301(a)(1), 29 U.S.C. § 1081(a)(1). Again, however, a state could assert under the authority of *FMC* that these requirements do not relate to reporting, disclosure or nonforfeitability.

Yet, in the face of the decision below, the prospects for employers having to face these possibilities are quite real.

Employers, plans and plan participants will not be alone in shouldering burdens created by the Third Circuit's faulty preemption analysis. The federal courts will face enormous difficulties in attempting to apply the "core ERISA concerns" test—difficulties that are inherent in the Third Circuit's own application of its creation.

For example, that court failed to recognize that a state anti-subrogation law affects the forfeitability of benefits under a welfare plan. The FMC plan covers medical costs arising out of automobile accidents, but benefits paid are subject to recapture by the plan in the event of another recovery. The Pennsylvania subrogation law, however, prohibits any right of subrogation or reimbursement from a participant's tort recovery with respect to medical claims paid. *See* 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984). By prohibiting the FMC plan from enforcing the conditional nature of the benefits, the Pennsylvania law treats the benefits as "vested." Thus, the law in fact addresses the "core ERISA concern" of nonforfeitability.[16]

This is obviously troublesome because Congress explicitly chose not to extend ERISA's vesting requirements to health and welfare plans. *See In Re: White Farm Equipment Co.*, 788 F.2d 1186 (6th Cir. 1986) (no absolute rule requiring mandatory vesting of retiree medical benefits; Congress expressly exempted welfare plans from stringent vesting, participation and funding requirements); *see also Metropolitan Life*, 471 U.S. at 732 (ERISA does not regulate substantive content of welfare benefit plans), *citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 91.

[16] *Cf. Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) (New Jersey law prohibiting offset of pensioner's workers' compensation benefits against his pension is preempted by ERISA; offset would ordinarily constitute impermissible forfeiture under ERISA, but is specifically permitted under lawful regulations of Internal Revenue Code).

Most disturbing of all, however, is that the Third Circuit was unable to apply its own test in a rational manner, which can only portend great confusion and uncertainty for other courts if the "core ERISA concern" rule is upheld. This Court might even have to reconsider the unanimous conclusion of the eight Justices who determined in *Metropolitan Life* that a state insurance law mandating particular benefits was preempted in its application to uninsured employee benefit plans. State mandated benefit laws generally fall outside of the areas the Third Circuit identified as subject to preemption (*i.e.*, reporting, disclosure, and nonforfeitability), and indeed, regulate an area which Congress expressly declined to touch.[17] The fact that the Third Circuit's unique preemption analysis would call into question a unanimous decision of this Court demonstrates its utter fallibility and its completely unworkable nature.

If the decision below is not reversed, the viability of the nation's uninsured welfare benefit plans will be threatened, the benefit security of millions of plan participants will be jeopardized, and the federal courts will be forced to sort through an endless series of disputes over the meaning and scope of the Third Circuit test. This Court should reverse the decision below and restore order to the regulation of employee welfare benefit plans.

[17] ERISA leaves the question of which benefits will be provided under a plan to the private parties creating it. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

CONCLUSION

The decision of the United States Court of Appeals for the Third Circuit should be reversed.

Respectfully submitted,

Of Counsel:
STEPHEN A. BOKAT
MONA C. ZEIBERG
CHAMBER OF COMMERCE
OF THE UNITED STATES
OF AMERICA
1615 H Street, N.W.
Washington, D.C. 20062
(202) 463-5337

MORGAN, LEWIS & BOCKIUS
1800 M Street, N.W.
Washington, D.C. 20036
(202) 467-7000

April 20, 1990

HARRY A. RISSETTO *
E. CARL UEHLEIN, JR.
MARGERY SINDER FRIEDMAN
LARISSA OMELCHENKO TARAN
1800 M Street, N.W.
Washington, D.C. 20036
(202) 467-7130

* Counsel of Record